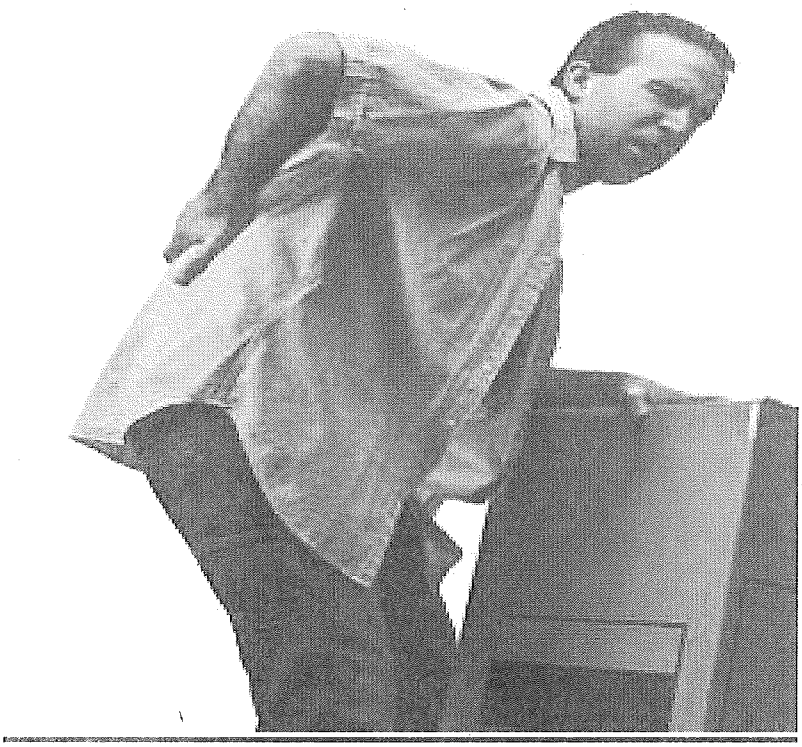
These Are Documents For The Doctor!



ACS Billing Card, Light Duty Card,

CA-17 Duty Status Report

CA-20 Attending Physician Report

Cards for the Doctor & Report Forms to HR!

Attending Physician's Report

U.S. Department of Labor

Office of Workers' Compensation Programs

Record of Examinaton

1. Patient's name Last First Middle	2. Date of Injury mo, day yr.	3. OWCP File Number	OMB No. 1240-0046 Expires: 10-31-2014

4. What history of injury (including disease) did patient give you?

5. Is there any history or evidence of concurrent or pre-existing injury or disease or physical impairment? (If yes, please describe) ☐ Yes ☐ No	ICD-9 Code

6. What are your findings? (Include results of X-Rays, laboratory reports, etc.)

7. What is your diagnosis?	ICD-9 Code

8. Do you believe the condition found was caused or aggravated by an employment activity? (Please explain answer) ☐ Yes ☐ No

9. Did injury require hospitalization? If no, go to item # 13 ☐ Yes ☐ No	10. Date of admission mo, day yr.	11. Date of discharge mo, day yr.	12. Additional Hospitalization required If Yes, describe in "Remarks" (Item 25) ☐ Yes ☐ No

13. What treatment did you provide?

14. Date of first examination mo. day yr.	15. Date(s) of treatment: mo. day yr. mo. day yr. mo. day yr.	16. Date of discharge from treatment mo. day yr.

17. Period of total disability From mo. day yr. Thru mo. day yr.	18. Period of Partial Disability From mo. day yr. Thru mo. day yr.	19. Date employee able to resume light work mo. day yr.

20. Date employee is able to resume regular work mo. day yr.	21. Has employee been advised that he/she can return to work? ☐ Yes ☐ No	22. If yes, on what date was he/she advised? mo. day yr.

23. If employee is able to resume only light work, indicate the extent of physical limitations and the type of work that could reasonably be performed with these limitations. (Continue in item #25 if necessary.)	24. Are any permanent effects expected as a result of this injury? If yes, describe in item #25. ☐ Yes ☐ No

25. Remarks

26. If you have referred the employee to another physician provide the following: Name	Specialty
Address	27. What was the reason for this referral?
City State ZIP	☐ Consultation ☐ Treatment

Signature

28. I certify that the statements in response to the questions asked above are true, complete and correct to the best of my knowledge. Further, I understand that any false or misleading statements or any misrepresentation or concealment of material fact which is knowingly made may subject me to felony criminal prosecution.

Signature of Physician _____ Date _____

29. Name of Physician	30. Tax ID Number
Address	31. Do you specialize? ☐ Yes ☐ No
City State ZIP	32. If yes, indicate specialty

INSTRUCTIONS TO PHYSICIAN FOR COMPLETING ATTENDING PHYSICIAN'S REPORT

1. COMPLETE THE ENTRIES 1-32 ON THE FORM; AND
2. IF DISABILITY HAS NOT TERMINATED, INDICATE IN ITEM 17; AND
3. SEND THE FORM AND YOUR BILL TO:

OFFICE OF WORKERS' COMPENSATION PROGRAMS
DOL DFEC Central Mailroom
PO Box 8300
London, KY 40742-8300

IMPORTANT: A MEDICAL REPORT IS REQUIRED BY THE OFFICE OF WORKERS' COMPENSATION PROGRAMS BEFORE PAYMENT OF COMPENSATION FOR LOSS OF WAGES OR PERMANENT DISABILITY CAN BE MADE TO THE EMPLOYEE. THIS INFORMATION IS REQUIRED TO OBTAIN OR RETAIN A BENEFIT (5 U.S.C. 8101, et seq.).

IF YOU HAVE SUBMITTED A NARRATIVE MEDICAL REPORT OR A FORM CA-16 TO OWCP WITHIN THE PAST 10 DAYS, YOU NEED NOT SUBMIT THIS FORM CA-20.

OWCP REQUIRES THAT MEDICAL BILLS, OTHER THAN HOSPITAL BILLS, BE SUBMITTED ON THE AMERICAN MEDICAL ASSOCIATION HEALTH INSURANCE CLAIM FORM, HCFA 1500/OWCP-1500.

INSTRUCTIONS FOR THE INJURED WORKER/ EMPLOYING AGENCY

Compensation for wage loss cannot be paid unless medical evidence has been submitted supporting disability for work during the period claimed. For claims based on traumatic injury and reported on Form CA-1, the employee should detach Form CA-20 and complete items 1-3 on the front. The form should be promptly referred to the attending physician for early completion. If the claim is for occupational disease, filed on Form CA-2, a medical report as described in the instructions accompanying that form is required in most cases. The employee should bring these requirements to the physician's attention. It may be necessary for the physician to provide a narrative medical report in place of or in addition to Form CA-20 to adequately explain and support the relationship of the disability to the employment.

For payment of a schedule award, the claimant must have a permanent loss or loss of function of one of the members of the body or organs enumerated in the regulations (20 C.F.R. 10.404). The attending physician must affirm that maximum medical improvement of the condition has been reached and should describe the functional loss and the resulting impairment in accordance with the American Medical Association Guides to the Evaluation of Permanent Impairment.

NOTICE

If you have a substantially limiting physical or mental impairment, Federal disability nondiscrimination law gives you the right to receive help from DFEC in the form of communication assistance, accommodation and modification to aid you in the FECA claims process. For example, we will provide you with copies of documents in alternate formats, communication services such as sign language interpretation, or other kinds of adjustments or changes to account for the limitations of your disability. Please contact our office or the claims examiner to ask about this assistance.

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Washington, DC 20402

Duty Status Report

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

This form is provided for the purpose of obtaining a duty status report for the employee named below. This request does not constitute authorization for payment of medical expense by the Department of Labor, nor does it invalidate any previous authorization issued in this case. This request for information is authorized by law (5 USC 8101 et seq.) and is required to obtain or retain a benefit. Information collected will be handled and stored in compliance with the Freedom of Information Act, the Privacy Act of 1974 and the OMB Cir. A-108. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

OMB No. 1215-0103
Expires: 08-31-02

OWCP File Number (If known)

SIDE A - Supervisor: Complete this side and refer to physician

1. Employee's Name (Last, first, middle)

2. Date of Injury (Month, day, yr.) | 3. Social Security No.

4. Occupation

5. Describe How the Injury Occurred and State Parts of the Body Affected

6. The Employee Works
Hours Per Day Days Per Week

7. Specify the Usual Work Requirements of the Employee. Check Whether Employee Performs These Tasks or is Exposed Continuously or intermittently, and Give Number of Hours.

Activity	Continuous	Intermittent	
a. Lifting/Carrying: State Max Wt.	#lbs.	#lbs.	Hrs Per Day
b. Sitting			Hrs Per Day
c. Standing			Hrs Per Day
d. Walking			Hrs Per Day
e. Climbing			Hrs Per Day
f. Kneeling			Hrs Per Day
g. Bending/Stooping			Hrs Per Day
h. Twisting			Hrs Per Day
i. Pulling/Pushing			Hrs Per Day
j. Simple Grasping			Hrs Per Day
k. Fine Manipulation (Includes keyboarding)			Hrs Per Day
l. Reaching above Shoulder			Hrs Per Day
m. Driving a Vehicle (Specify)			Hrs Per Day
n. Operating Machinery (Specify)			Hrs Per Day
o. Temp. Extremes			range in degrees F
p. High Humidity			Hrs Per Day
q. Chemicals, Solvents, etc. (Identify)			Hrs Per Day
r. Fumes/Dust (identify)			Hrs Per Day
s. Noise (Give dBA)			dBA Hrs Per Day
t. Other (Describe)			

SIDE B - Physician: Complete this side

8. Does the History of Injury Given to You by the Employee Correspond to that Shown in Item 5? ☐ Yes ☐ No (If not, describe)

9. Description of Clinical Findings

10. Diagnosis Due to Injury | 11. Other Disabling Conditions

12. Employee Advised to Resume Work?
☐ Yes, Date Advised ___/___/___ ☐ No

13. Employee Able to Perform Regular Work Described on Side A?
☐ Yes, If so ☐ Full-Time or ☐ Part-Time _____ Hrs Per Day
☐ No, If not, complete below:

Continuous	Intermittent	
#lbs.	#lbs.	Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		range in degrees F
		Hrs Per Day
		Hrs Per Day
		Hrs Per Day
		dBA Hrs Per Day

14. Are Interpersonal Relations Affected Because of a Neuropsychiatric Condition? (e.g. Ability to Give or Take Supervision, Meet Deadlines, etc.) ☐ Yes ☐ No (Describe)

15. Date of Examination | 16. Date of Next Appointment

17. Specialty | 18. Tax Identification Number

19. Physician's Signature | 20. Date

INSTRUCTIONS FOR COMPLETING DUTY STATUS REPORT (CA-17)

SUPERVISOR: Complete Side A and refer the form to the physician to complete Side B. Fill in the address of the Employing Agency and the appropriate OWCP District Office in the spaces below. Enter the OWCP file number in the top right corner.

PHYSICIAN: Complete Side B, sign and return to the employing agency within 2 days to prevent interruption of the employee's income. Fill in your name and address.

Medical Facility Name and Address

Send Original Report to:

Employing Agency Address

Send a Copy of This Report to:

OFFICE OF WORKERS' COMPENSATION PROGRAMS

CERTIFICATION: BY SIGNING BLOCK 19 ON THE FRONT OF THIS FORM, THE PHYSICIAN CERTIFIES AS FOLLOWS:

I CERTIFY THAT ALL THE STATEMENTS IN RESPONSE TO THE QUESTIONS ASKED ON THIS FORM CA-17 ARE TRUE, COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE. FURTHER, I UNDERSTAND THAT ANY KNOWINGLY FALSE OR MISLEADING STATEMENT, OR MISREPESENTATION OR CONCEALMENT OF MATERIAL FACT, MAY SUBJECT ME TO FELONY CRIMINAL PROSECUTION.

I FURTHER UNDERSTAND THAT THIS REQUEST DOES NOT CONSTITUTE AUTHORIZATION FOR PAYMENT OF MEDICAL EXPENSES BY THE DEPARTMENT OF LABOR, NOR DOES IT INVALIDATE ANY PREVIOUS AUTHORIZATION ISSUED IN THIS CASE.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE

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ACS
(Department of Military Affairs
Joint Forces Headquarters)

FEDERAL EMPLOYEES ARE COVERED BY THE U. S. DEPT OF LABOR, FEDERAL EMPLOYEES COMPENSATION ACT (FECA) FOR WORK-RELATED INJURIES.

Provider Enrollment Address:
Affiliated Computer Services (ACS) - Enrollment Unit
Department of Labor (DOL) , PO Box 14600
Tallahassee, FL 32317-4600

National Guard Federal Workers Compensation Contact (ICPA):

Name Kenneth Young Phone (608) 242-3711

This card is provided for informational purposes only and is not a guarantee of payment. (1 of 2)

ACS
Submit Medical Bills & Medical Documentation/Correspondence to:
U.S. Dept of Labor - OWCP, PO Box 8300, London, KY 40742-8300
Phone: (850) 558-1818 or (866) 335-8319 Toll Free IVR
ACS authorization fax # (800) 215-4901
ACS Website: http://owcp.dol.acs-inc.com

Prescription Benefit Inquiries: 1-866-664-5581

Provider Checklist:
- ☐ Provider enrolled with ACS/ ACS provider number on bill
- ☐ FECA Case # on medical bill & documentation
- ☐ Medical documentation submitted to the Department of Labor (DOL)
- ☐ Prior authorization requested
- ☐ Diagnosis code obtained from injured employee/ copy of DOL letter

This card is provided for informational purposes only and is not a guarantee of payment. (2 of 2)

FEDERAL TECHS LIGHT DUTY

(Department of Military Affairs
Joint Forces Headquarters)

FEDERAL EMPLOYEES ARE COVERED BY THE U. S. DEPT OF LABOR, FEDERAL EMPLOYEES COMPENSATION ACT (FECA) FOR WORK-RELATED INJURIES.

The Wisconsin National Guard has a light duty program
The Technician is required to maintain contact with supervisor whenever change of condition happens or continued total disability
The policy modifies duty assignments for technicians who present written medical
The Technician is required to inform the physician that light duty is available
National Guard Federal Workers Compensation Contact (ICPA):

Name Kenneth Young Phone (608) 242-3711

This card is provided for informational purposes only and is not a guarantee of payment. (1 of 2)

FEDERAL TECHS LIGHT DUTY

(Department of Military Affairs
Joint Forces Headquarters)

Once medical report indicates the technician is no longer totally disabled, he/she will be required to accept any reasonable suitable limited duty
The limited duty will be based on the physicians report stating types of work that can or cannot be performed.
Immediate supervisor is responsible for coordinating with HRO/ ICPA and assisting with identifying light duty assignment
If technician has to be reassigned based on light duty the offer has to be in writing
The offer must be confirmed in writing within 48 hours to be valid.
The technician is required to adhere to limited duty until cleared for full duty by medical provider In writing.
National Guard Federal Workers Compensation Contact (ICPA):

Name Kenneth Young Phone (608) 242-3711

This card is provided for informational purposes only and is not a guarantee of payment. (2 of 2)